

## Complete Summary

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### GUIDELINE TITLE

Breastfeeding promotion in the prenatal setting.

### BIBLIOGRAPHIC SOURCE(S)

Academy of Breastfeeding Medicine Protocol Committee. Clinical protocol number #19: breastfeeding promotion in the prenatal setting. Breastfeed Med 2009 Mar;4(1):43-5. [PubMed](#)

### GUIDELINE STATUS

This is the current release of the guideline.

Academy of Breastfeeding Medicine (ABM) protocols expire 5 years from the date of publication. Evidence-based revisions are made within 5 years or sooner if there are significant changes in the evidence.

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## SCOPE

### DISEASE/CONDITION(S)

Infant nutritional status and health

### GUIDELINE CATEGORY

Counseling  
 Evaluation  
 Management

### CLINICAL SPECIALTY

Family Practice  
Nursing  
Nutrition  
Obstetrics and Gynecology  
Pediatrics

## **INTENDED USERS**

Advanced Practice Nurses  
Dietitians  
Nurses  
Physician Assistants  
Physicians

## **GUIDELINE OBJECTIVE(S)**

To provide clinical protocols for managing common medical problems that may impact breastfeeding success

## **TARGET POPULATION**

Healthy newborn infants and their mothers

## **INTERVENTIONS AND PRACTICES CONSIDERED**

### **Counseling and Management**

1. Create a breastfeeding-friendly office
2. Integrate breastfeeding promotion, education, and support throughout prenatal care
3. Use a detailed breastfeeding history
4. Consider the culture of individual women, families, and communities
5. Incorporate breastfeeding as an important component of the initial prenatal breast examination
6. Discuss breastfeeding at each prenatal visit
7. Empower women and their families to have the birth experience most conducive to breastfeeding
8. Assure the mother has adequate support and access to information on how to get breastfeeding help

## **MAJOR OUTCOMES CONSIDERED**

- Rate of breastfeeding initiation
- Duration of breastfeeding

## **METHODOLOGY**

### **METHODS USED TO COLLECT/SELECT EVIDENCE**

Searches of Electronic Databases

## **DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE**

An initial search of relevant published articles written in English in the past 20 years in the fields of medicine, psychiatry, psychology, and basic biological science is undertaken for a particular topic. Once the articles are gathered, the papers are evaluated for scientific accuracy and significance.

## **NUMBER OF SOURCE DOCUMENTS**

16

## **METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Expert Consensus (Committee)  
Weighting According to a Rating Scheme (Scheme Given)

## **RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

### **Levels of Evidence**

**I** - Evidence obtained from at least one properly randomized controlled trial

**II-1** - Evidence obtained from well-designed controlled trials without randomization

**II-2** - Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group

**II-3** - Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.

**III** - Opinions of respected authorities, based on clinical experience, descriptive studies and case reports; or reports of expert committees

## **METHODS USED TO ANALYZE THE EVIDENCE**

Systematic Review with Evidence Tables

## **DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

An expert panel is identified and appointed to develop a draft protocol using evidence based methodology. An annotated bibliography (literature review), including salient gaps in the literature, are submitted by the expert panel to the Protocol Committee.

## **METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Expert Consensus

## **DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Not stated

## **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

Not applicable

## **COST ANALYSIS**

A formal cost analysis was not performed and published cost analyses were not reviewed.

## **METHOD OF GUIDELINE VALIDATION**

External Peer Review  
Internal Peer Review

## **DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

Draft protocol is peer reviewed by individuals outside of lead author/expert panel, including specific review for international applicability. Protocol Committee's sub-group of international experts recommends appropriate international reviewers. Chair (co-chairs) institutes and facilitates process. Reviews submitted to committee Chair (co-chairs).

Draft protocol is submitted to The Academy of Breastfeeding Medicine (ABM) Board for review and approval. Comments for revision will be accepted for three weeks following submission. Chair (co-chairs) and protocol author(s) amends protocol as needed.

Following all revisions, protocol has final review by original author(s) to make final suggestions and ascertain whether to maintain lead authorship.

Final protocol is submitted to the Board of Directors of ABM for approval.

## **RECOMMENDATIONS**

### **MAJOR RECOMMENDATIONS**

1. Create a breastfeeding-friendly office
  - Staff must be educated and committed to promote, protect, and support breastfeeding.
  - The primary clinician should be involved, but he or she does not need to do each of the following steps. Tasks may be assigned to multiple office staff members (nurses, medical assistants, lactation consultants,

- health and breastfeeding educators) if adequate training and support are provided for them.
- Offices providing prenatal care should have a written breastfeeding policy to facilitate such support (Academy of Breastfeeding Medicine Protocol Committee, 2006).
  - Literature and samples provided by artificial formula companies should not be used because this advertising has been demonstrated to decrease breastfeeding initiation and shorten duration rates (Howard, 2000).
  - Information regarding the mother's intention to breastfeed should be included as part of all transfer-of-care materials, including prenatal records and hospital and birth center discharge summaries.
2. Integrate breastfeeding promotion, education, and support throughout prenatal care
    - Actively state support of breastfeeding early in prenatal care and acknowledge that breastfeeding is superior to artificial feeding. Consider a statement such as "As your doctor, I want you to know that I support breastfeeding. It is important for mothers and babies."
    - It is also helpful to let the prenatal patient know that her physician will actively help her with statements such as "I like to spend time helping my patients get the information, skills, and support they need to breastfeed successfully."
  3. Take a detailed breastfeeding history as a part of the prenatal history (American Academy of Pediatrics, 2006).
    - For each previous child, ask about breastfeeding initiation, duration of exclusive breastfeeding, total breastfeeding duration, who provided breastfeeding support, perceived benefits of breastfeeding, breastfeeding challenges, and reason(s) for weaning.
    - For women who did not breastfeed, consider asking about the perceived advantages of artificial feeding, as well as the perceived disadvantages. Inquire about what may have helped her breastfeed previous children.
    - It is also important to determine any family medical history that may make breastfeeding especially helpful for this child, such as asthma, eczema, diabetes, and obesity (Gartner et al., 2005; American Academy of Family Physicians, 2008; Ip et al., 2007).
  4. Consider the culture of individual women, families, and communities
    - Learn about the family structure of patients. In some cultures, enlisting the cooperation of a pivotal family member may greatly assist in the promotion of breastfeeding, whereas in others, the participation of a particular family member may be inappropriate.
    - Understand the partner's perspectives and beliefs that may affect breastfeeding success and educate where appropriate.
    - Ensure that parents from diverse cultures understand the importance of breastfeeding to their children's growth and development.
    - Respect cultural traditions and taboos associated with lactation, adapting cultural beliefs to facilitate optimal breastfeeding, while sensitively educating about traditions that may be detrimental to breastfeeding.
    - Provide all information and instruction, wherever possible, in the mother's native language and assessing for literacy level when appropriate.

- Understand the specific financial, work, and time obstacles to breastfeeding and work with families to overcome them.
  - Be aware of the role of the physician's own personal cultural attitudes when interacting with patients (American Academy of Family Physicians, 2008).
5. Incorporate breastfeeding as an important component of the initial prenatal breast examination (Issler, de Sa, & Senna, 2001).
- Observe for appropriate breast development, surgical scars, and nipple contour.
  - Perform areolar compression if nipples are flat or inverted.
  - Review the physiologic changes of pregnancy, such as volume growth and leakage of colostrum.
  - Consider repeating the breast examination in the third trimester, as breast anatomy will change throughout pregnancy.
  - Assure the expectant mother that her anatomy is sufficient for successful breastfeeding or discuss the availability of support and assistance if suggested by physical exam.
  - If the history and or physical exam findings suggest that the woman is at high risk for breastfeeding problems, consider a prenatal lactation referral or early lactation support.
6. Discuss breastfeeding at each prenatal visit
- Breastfeeding can be addressed by clinicians and/or health care staff.
  - Consider use of the Best Start 3-Step Counseling Strategy (Issler, de Sa, & Senna, 2001) by:
    1. Encouraging open dialogue about breastfeeding by beginning with open-ended questions.
    2. Affirming the patient's feelings.
    3. Providing targeted education (United States Department of Agriculture, 2009; Humenick, Hill, & Spiegelberg, 1998)
      - Address concerns and dispel misconceptions at each visit.
  - *During the first trimester*
    - Incorporate and educate partners, parents, and friends about the benefits of breastfeeding for mothers and babies (Ingram & Johnson, 2004).
    - Address known common barriers such as lack of self-confidence, embarrassment, time and social constraints, dietary and health concerns, lack of social support, employment and child care concerns, and fear of pain (Issler, de Sa, & Senna, 2001, Hartley & O'Connor, 1996).
    - Continue to ask open-ended questions.
  - *During the second trimester*
    - Encourage women to identify breastfeeding role models by talking with family, friends, and colleagues who have breastfed successfully.
    - Recommend attending a formal breastfeeding course for the patient and her partner in addition to office education (Reifsnider & Eckhart, 1997).
    - Encourage participation in a breastfeeding peer support group. Provide a list of local educational options and breastfeeding resources for patients (Chapman, Damio, & Perez-Escamilla, 2004; Chapman et al., 2004).

- The second trimester visits often provide time for discussion of breastfeeding basics such as the importance of exclusive breastfeeding and supply/demand, feeding on demand, frequency of feedings, feeding cues, how to know an infant is getting enough to eat, avoiding artificial nipples until the infant is nursing well, and the importance of a good latch.
  - The mother working outside the home should be encouraged to begin thinking about if and when she will return to work after the baby is born. If she is planning on returning to work, encourage the woman to consider what facilities are available for pumping and storage of breastmilk, how much time she will take for maternity leave, and what company policies and legislation is available to support her.
  - *During the third trimester*
    - At the 28-, 30-, or 32-week visits have the prenatal patient and her support persons use props such as dolls, balls, and balloons. Demonstrate how to hold the breast and positions of the baby such as cradle, cross-cradle, and the clutch hold. (Duffy, Percival, & Kershaw, 1997).
    - Discuss what will happen in the delivery room under normal conditions. What will the mother do? What will the doctor do?
    - Review the physiology of breastfeeding initiation and the impact of supplementation.
    - Repeat the breast and nipple examination.
    - Recommend the purchase of properly fitting nursing bras.
    - Encourage another visit to a breastfeeding support group as the mother's interest and goals of attending may be different than when she attended early in the pregnancy (De Oliveira, Camacho, & Tedstone, 2001).
    - Recommend the mother discuss plans for infant health care and breastfeeding support with her pediatric care provider (Loh et al., 1997).
7. Empower women and their families to have the birth experience most conducive to breastfeeding
- Confirm postpartum follow-up plans.
  - Assure the mother has an adequate support system in place during the postpartum period.
  - Recommend the infant see a healthcare provider within 48 hours of discharge from the hospital to assure wellbeing and optimal breastfeeding.
  - Assure that the patient has information on how to get breastfeeding help.
  - Provide anticipatory guidance on topics such as engorgement, growth spurts, and nighttime feedings.
  - Inform patients about the Ten Steps to Successful Breastfeeding and how to advocate for breastfeeding friendly hospital care (American Academy of Pediatrics, 2003).
  - Discuss support of breastfeeding in the event of a Cesarean section.

## CLINICAL ALGORITHM(S)

None provided

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### REFERENCES SUPPORTING THE RECOMMENDATIONS

[References open in a new window](#)

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated.

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

Breastfeeding provides ideal infant nutrition. Encouragement and education from healthcare providers results in increased breastfeeding initiation and duration.

### POTENTIAL HARMS

Not stated

## QUALIFYING STATEMENTS

### QUALIFYING STATEMENTS

A central goal of The Academy of Breastfeeding Medicine is the development of clinical protocols for managing common medical problems that may impact breastfeeding success. These protocols serve only as guidelines for the care of breastfeeding mothers and infants and do not delineate an exclusive course of treatment or serve as standards of medical care. Variations in treatment may be appropriate according to the needs of an individual patient.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

### IMPLEMENTATION TOOLS

Foreign Language Translations

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Staying Healthy

### IOM DOMAIN

Effectiveness  
Patient-centeredness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

Academy of Breastfeeding Medicine Protocol Committee. Clinical protocol number #19: breastfeeding promotion in the prenatal setting. Breastfeed Med 2009 Mar;4(1):43-5. [PubMed](#)

### ADAPTATION

Not applicable: The guideline was not adapted from another source.

### DATE RELEASED

2009 Mar

### GUIDELINE DEVELOPER(S)

Academy of Breastfeeding Medicine - Professional Association

### SOURCE(S) OF FUNDING

Academy of Breastfeeding Medicine

A grant from the Maternal and Child Health Bureau, US Department of Health and Human Services

### GUIDELINE COMMITTEE

Academy of Breastfeeding Medicine Protocol Committee

### COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

*Lead Authors:* Julie Wood, M.D., FABM; Elizabeth Hineman, M.D.; David Meyers, M.D.

*Protocol Committee:* Caroline J. Chantry, M.D., FABM (Co-Chairperson); Cynthia R. Howard, M.D., MPH, FABM (Co-Chairperson); Ruth A. Lawrence, M.D., FABM; Kathleen A. Marinelli, M.D., FABM (Co-Chairperson); Nancy G. Powers, M.D., FABM

## **FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

None to report

## **GUIDELINE STATUS**

This is the current release of the guideline.

Academy of Breastfeeding Medicine (ABM) protocols expire 5 years from the date of publication. Evidence-based revisions are made within 5 years or sooner if there are significant changes in the evidence.

## **GUIDELINE AVAILABILITY**

Electronic copies: Available in Portable Document Format (PDF) from the [Academy of Breastfeeding Medicine Web site](#).

Print copies: Available from the Academy of Breastfeeding Medicine, 140 Huguenot Street, 3rd floor, New Rochelle, New York 10801.

## **AVAILABILITY OF COMPANION DOCUMENTS**

The following is available:

- Procedure for protocol development and approval. Academy of Breastfeeding Medicine. 2007 Mar. 2 p.

Print copies: Available from the Academy of Breastfeeding Medicine, 140 Huguenot Street, 3rd floor, New Rochelle, New York 10801.

A Korean translation of the original guideline document is available from the [Academy of Breastfeeding Medicine Web site](#).

## **PATIENT RESOURCES**

None provided

## **NGC STATUS**

This NGC summary was completed by ECRI Institute on March 10, 2010. The information was verified by the guideline developer on April 21, 2010.

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